REPORT ALL INJURIES IMMEDIATELY TO AST, POLICE OR VSPO

STATE OF ALASKA
BURN INJURY REPORT (File within 3 working days) Print or Type

VICTIM'S NAME (Last, First, MI)			
SEX: MALE _____ FEMALE _____	DATE OF BIRTH:		RACE:
VICTIM'S ADDRESS (Number, Street)			APT #
CITY	STATE	ZIP CODE	
DATE OF INJURY	TIME OF INJURY	PERCENT BURNED	DEGREE OF BURN 1st ____ 2nd ____ 3rd _____ Inhalation _____

AREAS OF THE BODY INJURED
(Circle Appropriate)

1. FACE, HEAD
2. NECK, SHOULDER
3. CHEST, ABDOMEN
4. BACK, BUTTOCKS
5. GROIN, GENITALS
6. LEG
7. FOOT
8. ARM
9. HAND
10. INTERNAL

INJURY SEVERITY
(Circle one)

1. MODERATE (Treated/Released)
2. SERIOUS (Hospitalized)
3. LIFE THREATENING (Death is Imminent and/or probable)
4. DEAD ON ARRIVAL

APPARENT CAUSE OF BURN INJURY (Please circle appropriate number)

1. CHEMICAL- Contact or exposure to reactive, caustic, corrosive or irritating substance
2. CONTACT W/ HOT OBJECT- Woodstove, stovepipe, furnace, iron, steampipe, exhaust pipe, etc.
3. COOKING- Stove, oven, hotplate, barbecue, hot grease
4. ELECTRICAL- Electrocution, electrical equipment & flashburns
5. EXPLOSIVES- Gunpowder, TNT, dynamite
6. FIREWORKS- Sparklers, firecrackers, rockets, smoke bombs, etc.
7. FLAMMABLE LIQUIDS- Ignition of flammable/combustible liquids; gasoline, kerosene, diesel fuel
8. GAS/VAPOR EXPLOSION- Ignition of flammable gases or explosion of flammable liquid vapors
9. HOT LIQUID- Hot water, coffee, tea, hot food, hot tar, melted plastic, etc.
10. OTHER OPEN FLAME- Welding, matches, lighter, torch, etc.
11. OUTSIDE FIRES- Grass, brush, forest, bonfires, dump, trash and refuse fires, etc.
12. RADIATION- Burns cause by contact or exposure to any radioactive materials
13. STEAM- Caused by escaping steam from radiators, boilers, pipes, etc.
14. STRUCTURE FIRE- Any uncontained burning within a structure, including smoking accidents
15. SUNBURN- Exposure to ultraviolet light, including sunlamps
16. VEHICLE FIRE- Car, truck, boat, tractor, lawnmower, etc.

REPORTING FACILITY			
ADDRESS OF REPORTING FACILITY			
CITY	STATE	ZIPCODE	
NAME: HEALTH CARE PROVIDER			DATE
PERSON FILLING OUT REPORT (Signature)			
DID THIS INJURY RECEIVE PRIOR TREATMENT (Transfer)? IF SO, WHERE?			